

## ELDERLY HEALTHCARE AND BUDGET CONSTRAINTS<sup>†</sup>

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*The author contextualizes the effects of public funding constraints on the creation (by the legislator) of elderly healthcare and on potential for its judicial review, examining the relationship between economic issues and the conflicts that arise because the healthcare that is actually provided for by law and covered by the public budget and administrative procedures falls short of individuals' expectations and demands. The paper observes that the shortage of funds and public budgetary resources, although it creates a risk of a restricted scope of judicial protection of rights, is not necessarily an obstacle to judicial review of healthcare cases, nor does it prevent the exercise of any other statutory rights; to admit otherwise, would be an insult to the Rule of Law. Finally, the paper points out the need for a better understanding of the expression the "existential minimum" (Existenzminimum) of healthcare for the elderly, as guidance for legislators, based on the financial realities of nations in such a way as to make commitments only to such services as are actually possible, without generating frustrations in society.*

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## Introduction

The relationship between budgetary resources and healthcare rights is a frequently mentioned topical issue. Incidentally, since June 2013, Brazil has been witnessing unprecedented mass protests arising from complaints that are unrelated to party politics.<sup>1</sup> The reason for the protests is that essential social rights and public services, especially in the public healthcare sector, no longer meet the expectations of Brazilian society.<sup>2</sup> The government, in self-defense, alleges that it lacks the financial resources to meet this booming demand.<sup>3</sup>

The financial difficulties are exacerbated in the case of elderly healthcare,<sup>4</sup> since the population is constantly aging as life expectancies increase,<sup>5</sup> and the elderly are demanding a broader range of special treatments as the technological advances are made.<sup>6</sup>

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1. Marcus Abraham, *Direito é Ferramenta Fundamental de Transformação Social* [Law is a Fundamental Tool of Social Transformation], CONSULTOR JURIDICO (July 13, 2013), <http://www.conjur.com.br/2013-jul-03/marcus-abraham-direito-ferramenta-fundamental-transformacao-social#autores> [hereinafter Abraham].

2. See generally *id.*; see also Sabine Righetti, *Protestos pela saúde pública 'enterra' Dilma e ministros e critica governo* [Public health protests "bury" Dilma and ministers and criticize government], FOLHA DE S. PAULO (Oct. 10, 2013), <http://www1.folha.uol.com.br/fsp/cotidiano/119355-protesto-pela-saude-publica-enterra-dilma-e-ministros-e-critica-governo.shtml>; *Manifestação por Mais Transporte, Saúde e Educação* [Protest for More Transportation, Health, and Education], VALOR ECONÔMICO (June 19, 2013), <http://www.valor.com.br/politica/3167272>.

3. Abraham, *supra* note 1.

4. In Brazil, in the year 2011 alone, the SUS spent approximately \$701,391,688,66 on medicine for the elderly (the forecasted expenditure up to the year 2030 amounts to \$63.5 billion). *Destaques*, CANAL SAUDE, <http://www.canal.fiocruz.br/destaque/index.php?id=859> (last visited Nov. 28, 2016).

5. "The world population is ageing at a steady, quite spectacular rate. The total number of persons aged 60 and above rose from 200 million in 1950 to 400 million in 1982 and is projected to reach 600 million in the year 2001 and 1.2 billion by the year 2025, at which time over 70 percent of them will be living in what are today's developing countries. The number of people aged 80 and above has grown and continues to grow even more dramatically, going from 13 million in 1950 to over 50 million today and projected to increase to 137 million in 2025. This is the fastest growing population group in the world, projected to increase by a factor of 10 between 1950 and 2025, compared with a factor of six for the group aged 60 and above and a factor of little more than three for the total population." THE ECONOMIC, SOCIAL AND CULTURAL RIGHTS: A LEGAL RESOURCE GUIDE 307, (Scott Leckie & Anne Gallagher eds., 2011). According to the IBGE [Brazilian Institute of Geography and Statistics], in 2003 there were 16,022,231 older persons in Brazil, corresponding to 9.3% of the population; in 2009, they increased to 21,736,304 old-

In this highly polemical situation, it is worth noting that the Minister of Finance of Japan, the world's third-biggest economic power, recently called upon the old people of his country "to hurry up and die" in order to lighten the Japanese tax burden for medical care.<sup>7</sup> He decried intensive care units and life-prolonging treatments, saying that he would feel bad about their helping to prolong his life, especially knowing that the treatment was "paid for by the State."<sup>8</sup> In a National Social Security Council meeting on the reforms to be implemented in order to alleviate the tax burden, he said that "the problem will not be solved unless we hurry up and let them die."<sup>9</sup> Aso added:

I said what I believe personally: that it is important not to prolong life with treatments and to spend the last days of your life in peace. Nearly one fourth of the Japanese population of 128 million is over sixty years of age, and one British newspaper predicts that age bracket will increase by forty percent in the next fifty years. The increase in social expenditure, especially for the elderly, resulted in a ten percent increase in excise duties last year. Also, who is inclined to make polemical statements, tried to qualify his words hours later. He admitted that he expressed himself "inadequately" and insisted that he was only speaking personally about the way in which he wanted to die. "I told them what I personally believe: that it is important not to prolong life with treatments and to spend the last days of your life in peace."<sup>10</sup>

In the final analysis, does the public budget really limit healthcare, particularly for the elderly? According to the Office of the United Nations High Commissioner for Human Rights,

it is often argued that States that cannot afford it are not obliged to take steps to realize this right or may delay their obligations

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er persons, equivalent to 11.3% of the population. *Síntese de Indicadores Sociais* [Summary of Social Indicators], INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA, [http://www.ibge.gov.br/home/estatistica/pesquisas/pesquisa\\_resultados.php?id\\_pesquisa=47](http://www.ibge.gov.br/home/estatistica/pesquisas/pesquisa_resultados.php?id_pesquisa=47) (last visited Nov. 28, 2016).

6. See Martha B. Paláez & Marcela Ferrer Lues, *Salud Pública y los Derechos Humanos de los Adultos Mayores* [Public Health and Human Rights of Older Persons], ACTA BIOETH 143 (2001) [hereinafter Paláez].

7. *El Ministro de Finanzas Japones, Taro Aso, Sobre los Ancianos: "Que se den Prisa y se Mueran"* [The Japanese Minister of Finance, Taro Aso, on Elder Persons: "Let Them Hurry Up and Die"], 20 MINUTOS (Jan. 22, 2013), <http://www.20minutos.es/noticia/1707874/0/taro-aso/ministro-Japon/que-se-den-prisa-y-se-mueran/#xtor=AD-15&xts=467263> [hereinafter 20 MINUTOS].

8. *Id.*

9. *Id.*

10. *Id.*; see also Alana Gandra, *Mudanças Demográficas Aumentarão Demandas por Previdência Social e Saúde* [Demographical Changes Increase Social Security and Health Care Claims], EMPRESA BRASIL DE COMUNICAÇÃO: AGENCIA BRASIL (Aug. 4, 2013), <http://agenciabrasil.ebc.com.br/noticia/2013-08-14/mudancas-demograficas-aumentarao-demandas-por-previdencia-social-e-saude>.

indefinitely.<sup>11</sup> When considering the level of implementation of this right in a particular State, the availability of resources at that time and the development context are taken into account. Nonetheless, no State can justify a failure to respect its obligations because of a lack of resources. States must guarantee the right to health to the maximum of their available resources, even if these are tight. While steps may depend on the specific context, all States must move<sup>12</sup> towards meeting their obligations to respect, protect, and fulfill.

I therefore think that various aspects should be considered in advance. Is health care a fundamental right? Do the elderly have fundamental rights to health care? Are they absolute fundamental social rights? Is it important to distinguish between procedural and substantive health care rights? What is the impact of the financial realities of the public authorities on health policies? What conflicts can arise when the public healthcare budget is insufficient? How can court judgements be enforced if the health care authorities are out of funds? What exactly is the “existential minimum” (*Existenzminimum*) in terms of the procedural and substantive aspects of the right to health? Does the existential minimum have specific features in relation to health care for older persons?

## 1. Is Health Care a Fundamental Positive Social Right?

### 1.1 International Bases

The international community overwhelmingly answers this question in the affirmative: “Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.”<sup>13</sup>

In fact, in the national, regional, and international legal systems, healthcare is generally associated with a fundamental social right.<sup>14</sup>

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11. Off. Of the U.N. Comm’r for Hum. Rts. (OUNHCHR) & World Health Org. (WHO), *The Right to Health: Fact Sheet No. 31*, 5 (June 2008), <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf> [hereinafter *Fact Sheet*].

12. *Id.*

13. OUNHCHR, Comm. on Econ., Soc. and Cultural Rts., *General Comment 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C. 12/2004/4 (May 11, 2008), <http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/GC14.pdf> [hereinafter *General Comment 14*].

14. *Id.*

On the international scale,<sup>15</sup> it is particularly worth noting the International Covenant on Economic, Social and Cultural Rights of 1966, Article 12 of which stipulates as follows:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.<sup>16</sup> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; [and] (d) The creation of conditions which would assure to <sup>all</sup> medical service and medical attention in the event of sickness.<sup>17</sup>

Additionally, the right to health is recognized, *inter alia*, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965,<sup>18</sup> in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979<sup>19</sup> and in article 24 of the Convention on the Rights of the Child of 1989.<sup>20</sup>

Various statements and recommendations in an international context associate healthcare with fundamental human rights,<sup>21</sup> such as

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15. *Id.*

16. Int'l Covenant on Econ., Soc. and Cultural Rts. Art 12, Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter Int'l Covenant].

17. *Id.*

18. Int'l Health Law and Ethics: Basic Documents 18 (André de Exter ed., 2015).

19. *Id.*

20. *Id.*

21. United Nations High Comm'r for Refugees, Guiding Principles on Internal Displacement (Sept. 2004); Madrid International Plan of Action on Ageing (2002); G.A. Res. 53/144, Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms (Dec. 9, 1998); G.A. Res. 29, Universal Declaration on the Human Genome and Human Rights (Nov. 11, 1997); G.A. Res. 48/104, Declaration on the Elimination of Violence Against Women (Dec. 20, 1993); G.A. Res. 48/96, Standard Rules on the Equalization of Opportunities for Persons with Disabilities (Dec. 20, 1993); G.A. Res. 47/135, Declaration on the Rights of Persons Belonging to Nat'l or Ethnic, Religious and Linguistic Minorities (Dec. 18, 1992); G.A. Res. 46/119, Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (Dec. 17, 1991); G.A. Res. 46/91, United Nations Principles for Older Persons (Dec. 16, 1991); G.A. Res. 41/128, Declaration on the Right to Development (Dec. 4, 1986); G.A. Res. 37/194, Principles of Medical Ethics Relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Dec. 18, 1982); G.A. Res. 3447 (XX), Declaration on the Rights of Disabled Persons (Dec. 9, 1975); G.A. Res.

The Universal Declaration of Human Rights of 1948, Article 25, § 1<sup>o</sup>, of which stipulates that:

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.<sup>22</sup>

By the way, a revised version of the Universal Declaration of Human Rights of 1948 shows that most of the rights and freedoms mentioned therein are components and determinants of health.<sup>23</sup>

It is also worth pointing out the Constitution of the World Health Organization (“WHO”),<sup>24</sup> the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.

## 1.2 Regional Human Rights Norms

On the regional scene,<sup>25</sup> the American, European, African and Islamic human rights systems are particularly noteworthy.

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3384 (XXX), Declaration on the Use of Scientific and Technological Progress in the Interests of Peace for the Benefit of Mankind (Nov. 10, 1975); G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948). The Universal Human Rights Declaration was proclaimed by the United Nations General Assembly in Paris, on 10 December 1948, through Resolution 217 A (III) of the General Assembly. International declarations, rules, and regulations related to the right to health; Decreto No.3.956, de 8 Outubro de 2001, Diário da União [D.O.U.] de 9.10.2001 (Braz.).

22. G.A. Res. 217(111) A, Universal Declaration of Human Rights, art. 25 (Dec. 10, 1948).

23. Peláez, *supra* note 6.

24. WHO, *Constitution*, 45, 41 (2006), [http://www.who.int/governance/eb/who\\_constitution\\_en.pdf](http://www.who.int/governance/eb/who_constitution_en.pdf). The Constitution was adopted by the International Health Conference held in New York from June 19 to July 22, 1946, signed on July 22, 1946 by the representatives of sixty-one nations, and entered into effect on April 7, 1948. The reforms adopted by the 26th, 29th, 39th and 51st World Health Assemblies (resolutions WHA26.37, WHA29.38, WHA39.6 and WHA51.23), which entered into effect on February 3, 1977, January 20, 1984, July 11, 1994 and September 15, 2005, respectively, have been incorporated into the present text.

25. Other regional human rights instruments in the area of health care: Inter-American Convention on the Elimination of all Forms of Discrimination Against Persons with Disabilities, Jun. 8, 1999; African Charter on the Rights and Welfare of the Child, Nov. 29, 1999, CAB/LEG/24.9/49; Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Apr. 4, 1997, Oviedo, 4.IV.1997; Inter-American Convention on the Prevention, Punish-

Article 11 of The American Declaration of the Rights and Duties of Man of 1948 stipulates that: "Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources."<sup>26</sup>

The Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights "Protocol of San Salvador," adds the following provisions:

1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental, and social well-being.
2. In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right:
  - (a) Primary health care, that is, essential health care made available to all individuals and families in the community;
  - (b) Extension of the benefits of health services to all individuals subject to the State's jurisdiction;
  - (c) Universal immunization against the principal infectious diseases;
  - (d) Prevention and treatment of endemic, occupational, and other diseases;
  - (e) Education of the population on the prevention and treatment of health problems; and
  - (f) Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.

Article 11 of The European Social Charter of 1996 on "The right to protection of health" reads as follows:

- With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed *inter alia*:
1. to remove as far as possible the causes of ill-health;
  2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
  3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.<sup>28</sup>

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ment and Eradication of Violence against Women "Convention of Belem do Pará", June 9, 1994; Protocol to the American Convention on Human Rights to Abolish the Death Penalty, June 8, 1990, OAS Treaty Series 73; Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights "Protocol of San Salvador", Nov. 17, 1988, OAS Treaty Series 69; Inter-American Convention to Prevent and Punish Torture, Dec. 9, 1985, OAS Treaty Series 67; American Convention on Human Rights "Pact of San José, Costa Rica", Nov. 22, 1969, U.N.T.S. 36; Decreto No. 1.973, de 1 de Agosto de 1996, Diário da União [D.O.U.] de 1.8.1996 (Braz.).

26. Organisation of American States (OAS), Declaration of the Rights and Duties of Man, May 2, 1948.

27. Additional Protocol to the Am. Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador" art. 12, Nov. 17, 1988. U.N.T.S. 69 [hereinafter Protocol of San Salvador].

28. Eur. Soc. Charter art. 11, Strasbourg, Jan. 7, 1999, E.T.S. No. 163.

Similarly, according to Article 35 of the Charter of Fundamental Rights of the European Union of 2007:

Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities.<sup>29</sup>

According to Article 16 of The African Charter on Human and Peoples' Rights of 1981:

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health. 2. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.<sup>30</sup>

Finally, the Article 17 (b) of the controversial Political Rights and Economic, Social and Cultural Rights and the Cairo Declaration on Human Rights in Islam of 1993, stipulates that "everyone shall have the right to medical and social care, and to all public amenities provided by Society and the State within the limits of their available resources."<sup>31</sup>

### 1.3 National Constitutions

According to Hogerzeil *et al.*:

Most countries in the world have acceded to or ratified at least one worldwide or regional covenant or treaty confirming the right to health. For example, more than 150 countries have become State parties to the International Covenant on Economic, Social and Cultural Rights - ICESCR, and 83 have signed regional treaties. More than 100 countries have incorporated the right to health in their national constitution.<sup>32</sup>

From the perspective of national law, many countries have incorporated the right to health in their constitutions.

29. Charter of Fundamental Rights of the Eur. Union 2007/C. 2007 O.J. (C303) 1 (EC). The EU Charter of Fundamental Rights was "solemnly proclaimed" by the European Parliament, the EU Council and the European Commission on December 7, 2000. A revised version of the Charter was proclaimed on December 12, 2007, in Strasbourg, on the occasion of the signature of the Lisbon Treaty.

30. Org. of African Unity (OAU) Charter on Human and Peoples' Rights art. 16 § 2.

31. G.A. Res. 49/19, The Cairo Declaration on Human Rights in Islam (Aug. 5, 1990).

32. Hans V. Hogerzeil *et al.*, *Is Access to Essential Medicines as Part of the Fulfillment of the Right to Health Enforceable through the Courts?*, THE LANCET, 305, 306 (2006) [hereinafter Hogerzeil]; *see* Int'l Covenant, *supra* note 16.

Relevant national laws include, in particular, those of Brazil, Portugal, the Netherlands, the United Kingdom, and the USA.<sup>33</sup> According to Article 196 of the Brazilian Federal Constitution:

Health is a right of all and a duty of the state and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection, and recovery.<sup>34</sup>

Article 64 of the Portuguese Constitution prescribes the following health care rights:

1. Everyone shall possess the right to health protection and the duty to defend and promote health. 2. The right to health protection shall be fulfilled: (a) By means of a national health service that shall be universal and general and, with particular regard to the economic and social conditions of the citizens who use it, shall tend to be free of charge...<sup>35</sup>

Article 22 of the Dutch Federal Constitution:

Assures the right to good care. All those who live and/or work in the Netherlands must have basic healthcare insurance, but those who do not are still entitled to basic care (though they are breaking the law). This is monitored by the Healthcare Insurance Board.<sup>36</sup>

The UK and US Constitutions and legal systems do not provide for health care.<sup>37</sup> It is clear that in these systems, typical of negative freedoms, the notion predominates that fundamental rights merely authorize procedural rights to public health policies.<sup>38</sup> The UK Human

33. For example, *see* art. 42, CONSTITUCIÓN NACIONAL [CONST. NAC.] (Arg.); CONSTITUCIÓN POLÍTICA DE LA REPÚBLICA DE CHILE [C.P.] art. 19, 9; XIANFA art. 21, 45, 70, 89, 107, 111, 119 (1982) (China); CONSTITUTION DE POLITICA DE COLOMBIA [C.P.] art. 49, 50, 64, 300, 366; Constitution of the Republic Costa Rica, Nov. 7, 1949, art. 46 (Costa Rica); Cuba Constitution, Feb. 24, 1976, art. 43; *id.* 44; *id.* 50; *id.* 103; *id.* 104; *id.* 105 § h; *id.* 106 §h (Cuba); Constitution of Finland, June 11, 1999, art. 19 (Fin.); NIHONKOKU KENPŌ [KENPŌ] [CONSTITUTION], art. 25; [see pg. 408] Constitution of Mexico, Feb. 5, 1917, art. 2 §§ b III; *id.* at 4; *id.* at 122 (Mex.); BUNDESVERFASSUNG [BV] [CONSTITUTION] pr. 18, 1999, SR 101, art. 41, 117, 118, 119. (Switz.); Constitution of the Bolivarian Republic of Venezuela, Jan. 6, 1961, art. 83; *id.* at 84; *id.* at 85; *id.* at 86; *id.* at 122; *id.* at XXIII; *id.* at XXIV; *id.* at 184 § I (Venez.).

34. CONST. OF THE FED. REPUBLIC OF BRAZ., Oct. 5, 1988, art. 196.

35. CONST. OF THE PORT. REPUBLIC, Apr. 25, 1976, art. 64.

36. Hogerzeil, *supra* note 32.

37. Elizabeth Pascal, *Welfare Rights in State Constitutions*, 39 RUTGERS L.J. 863, 869-70 (2008). "The United States constitution does not provide for affirmative rights, however, several State constitutions include such provisions. Despite scholarly calls for State courts to enforce affirmative rights, State courts have not taken the opportunity to review State constitution welfare provisions."

38. *See generally* Mark Tushnet, *Social Welfare Rights and the Forms of Judicial Reviews*, 82 TEX. L. REV. 1895 (2004). On procedural and substantive right, *see*

Rights Act lays down guidelines for institutions associated with the National Health Service (“NHS”), based on the principle of the right to life, dignity, and privacy, in particular, but it does not therefore conclude that citizens have a right to medicines, healthcare services, and products under any circumstances.<sup>39</sup>

In the US, healthcare systems have always been mainly private, except for Medicare and Medicaid and, most recently, the Affordable Care Act (“ACA”), which calls for greater involvement of the public authorities in healthcare.<sup>40</sup>

In the US and UK systems, typified by negative freedoms, the predominant notion is clearly that the fundamental rights authorize public healthcare policies to cover procedural rights alone.

## 2. Fundamental Positive Rights to Elderly Healthcare?

According to Article 17 of the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social, and Cultural Rights (“Protocol of San Salvador”), everyone has the right to special protection in old age and the States should progressively take steps to provide the elderly with specialised medical assistance.<sup>41</sup>

Regarding elderly healthcare, it should be pointed out that:

Human rights are by definition universal. By virtue of the universal scope of all rights, the whole range of internationally recognized human rights standards and principles, as contained in core international human rights treaties, also covers and protects older persons.<sup>42</sup>

The Covenants, on Economic, Social, and Cultural Rights and on Civil and Political Rights include highly relevant provisions for the protection of human rights of older persons, such as the rights to health, to an adequate standard of living, to freedom from torture, legal capacity, and equality before the law.<sup>43</sup>

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Chapter 5 of this article. Note that Mark Tushnet tends to consider that positive social and economic rights [*welfare rights*] beyond the basic core needs, fundamental rights or strong substantive rights are not subject to judicial review.

39. *Bringing Human Rights to Life Here at Home*, THE BRITISH INST. OF HUMAN RIGHTS, <http://www.bih.org.uk/sites/default/files/Human%20rights%20in%20healthcare%20-%20short%20introduction.pdf> (last visited Nov. 28, 2016).

40. See Mariana Rodrigues Kelly Souza, *Princípio da universalidade: efeitos da reforma introduzida pelo Affordable Care Act* [*Principle of universality: effects of reform introduced by the Affordable Care Act*], NITERÓI: UFF (2012).

41. Protocol of San Salvador, *supra* note 27.

42. *International Standards and Principles*, UNITED NATIONS ORGANIZATION (ONU), <http://www.ohchr.org/EN/Issues/OlderPersons/Pages/InternationalStandards.aspx> (last visited Nov. 28, 2016) [hereinafter ONU].

43. *Id.*

Other instruments, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Elimination of All Forms of Racial Discrimination (CERD) also contain provisions which are applicable to older persons within their relevant scope.<sup>44</sup> The International Convention on the Protection of the Rights of Migrant Workers and the members of their families (ICMW), article 7,<sup>45</sup> includes “age” in the list of prohibited grounds for discrimination.

In 1991, the Assembly adopted the “United Nations Principles for Older Persons” (Resolution 46/91),<sup>46</sup> encouraging governments to incorporate:

10. Older persons should benefit from family and community care and protection in accordance with each society’s system of cultural values. 11. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental, and emotional well-being and to prevent or delay the onset of illness. 12. Older persons should have access to social and legal services to enhance their autonomy, protection, and care. 13. Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation, and social and mental stimulation in a humane and secure environment. 14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care, or treatment facility, including full respect for their dignity, beliefs, needs, and privacy and for the right to make decisions about their care and the quality of their lives.<sup>47</sup>

Article 14 of the Madrid International Plan of Action on Ageing, resulting from the Second World Assembly on Ageing held in Madrid in 2002, which was promoted by the UN, reads as follows:

We commit ourselves to providing older persons with universal and equal access to health care and services, including physical and mental health services, and we recognize that the growing needs of an ageing population require additional policies, in particular care and treatment,<sup>48</sup> the promotion of healthy lifestyles and supportive environments.

The Office of the High Commissioner for Human Rights (“OHCHR”) of the United Nations developed a background paper entitled “Human rights of older persons: International Principles and

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44. *Id.*

45. *Id.*

46. G.A. Res. 46/91 (Dec. 16, 1991).

47. *Id.*

48. Political Declaration and Madrid Int’l Plan of Action on Ageing, SECOND WORLD ASSEMBLY ON AGEING 2002, art. 14 (Apr. 8-12, 2016), [http://www.un.org/en/events/pastevents/pdfs/Madrid\\_plan.pdf](http://www.un.org/en/events/pastevents/pdfs/Madrid_plan.pdf).

Standards" for the Expert Group Meeting that took place May 5 through May 7, 2010.<sup>49</sup>

On the international scenes, the following texts should be noted, as well: The Committee on the Elimination of Discrimination against Women ("CEDAW") General Recommendation No. 27 on older women and protection of their human rights;<sup>50</sup> The Committee on Economic, Social and Cultural Rights ("CESCR"), General Comment No. 6 on the economic, social and cultural rights of older persons;<sup>51</sup> The CESCR, General Comment No. 19 on the right to social security.<sup>52</sup>

### 3. Absolute Fundamental Positive Social Rights?<sup>53</sup>

Fundamental rights enjoy a broad scope of protection, despite being subject to proportionate, constitutionally justifiable restrictions.<sup>54</sup> Restrictions of fundamental positive social rights may be imposed in cases in which the public authorities are found to have made an omission or to have acted too timidly;<sup>55</sup> in such cases, the restrictions imposed must be proportionate and anchored in fundamental constitutional principles.<sup>56</sup> The notion of an "existential minimum" coincides with the essential substance of a fundamental positive social right combined with the principle of human dignity. The scope of protection offered by the existential minimum (*Existenzminimum*)<sup>57</sup> is a

49. *Human Rights of Older Persons: Int'l Human Rights Principles and Standards*, U.N. ORG. <http://www.ohchr.org/Documents/Issues/OlderPersons/OHCHRBackgroundpaper2011.pdf>.

50. See generally Comm. On the Elimination of Discrimination Against Women, General Recommendation No. 27 on Older Women and Protection of their Human Rights, U.N. Doc. CEDAW IC/2010/47/GC.1 (Oct. 19, 2010).

51. See generally Comm. On Econ., Soc., and Cultural Rts, Gen. Comment No.6 on the Econ., Soc. And Cultural Rts. of Older Persons, U.N. Doc. E/C.12/GG/20 (July 2, 2009).

52. See U.N. Off. of the U.N. High Comm'r for Human Rights, *Standards and Principles* (Sept. 19, 2016), <http://www.ohchr.org/EN/Issues/OlderPersons/Pages/InternationalStandards.aspx>.

53. Ricardo Perlingeiro, *Does the Precondition of the Possible (Vorbehalt Des Möglichen) Limit Judicial Intervention in Social Public Policies?* 2 NLUO L. J. INDIA, (SPECIAL ISSUE) 20, 45 (2015) [hereinafter Perlingeiro].

54. Virgílio Afonso da Silva, *Direitos fundamentais [Fundamental Rights]*, SÃO PAULO: MALHEIROS, 74-75, 154 (2011) [hereinafter Silva].

55. Perlingeiro, *supra* note 53.

56. Silva, *supra* note 54, at 77-78.

57. See Céline Fercot, *Droits des Pauvres, Pauvres Droits? [Rights of the Poor, Poor Rights?]*, UNIVERSITÉ PARIS OUEST NANTERRE LA DEFENSE, 227, 239-243 (2012), <http://revdh.files.wordpress.com/2012/04/le-juge-et-le-droit-au-minimum.pdf>.

According to Céline Fercot, the right to a certain minimum may be based on a variety of factors: on human dignity, in an autonomous manner, as in Israel, or

logical corollary of applying the rule of proportionality to the specific case (which is not necessarily limited to individual situations but may also involve collective situations).<sup>58</sup> According to Alexy,

Restrictions in line with the principle of proportionality do not violate the guarantee of the essential substance, even if, in the specific case, nothing remains of the fundamental right in question and, in the specific case of the right to an existential minimum, in social rights, the weighing of interests might lead, under different circumstances, to distinct definite rights.<sup>59</sup>

Starting from a different premise, namely that the fundamental rights have reduced scope of protection so that the *minimum* should be considered absolute<sup>60</sup> in matters of human dignity, law-makers should be granted a narrow margin of discretion or none at all.

It is not always easy to reach a proper understanding of the “*minimum*,” however. Incidentally, Pieroth and Schlink observed that “determining the extent of the Social State’s responsibility from the standpoint of human dignity especially depends on the standards and affluence of the society in question;<sup>61</sup> while case law speaks of maintaining an existential minimum, that is a criterion that depends on the time and situation at hand.”<sup>62</sup>

According to a recent precedent of the German Constitutional Court in 2010,<sup>63</sup> citizens have the right to demand the material prerequisites indispensable to their physical existence (food, clothing, household articles, social housing, heating, sanitation and health) and at least a minimum of participation in social, cultural and political life,

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linked with the Social Welfare State, on the models of Germany and Colombia. She also mentions that the right to a certain minimum can be derived directly from the right to life, as in India, or from a combination of the right to life and dignity, as in South African law (*Le juge et le droit au minimum. Les ambiguïtés du droit a des conditions minimales d’existence en droit comparé*).

58. JOSEF ISENSE & PAUL KIRCHHOE, HANDBUCH DES STAATSRICHT § 99 (vol. v. Heidelberg, 2007). The “precondition of the possible” expresses the “principle of proportionality” with respect to the State budget. Silva, *supra* note 54, at 197, 204; Robert Alexy, *Teoria dos Direitos Fundamentais* [*Theory of Fundamental Rights*], SÃO PAULO: MALHEIROS, 297-98 (2008) [hereinafter Alexy].

59. Alexy, *supra* note 58, at 513.

60. Alexy, *supra* note 58, at 298-301 (noting that the German Federal Constitutional Court has precedents tending to confirm the absolute nature of the essential core [needs]).

61. BODO PIEROTH & BERNHARD SCHLINK, DIREITOS FUNDAMENTAIS [FUNDAMENTAL RIGHTS], 172 (São Paulo, Saraiva, 2012) [hereinafter PIEROTH].

62. *Id.*

63. BVerfGE, 1 BvL 1/09, 1 BvL 3/09, 1 BvL 4/09, Feb. 9, 2010, [http://www.bundesverfassungsgericht.de/entscheidungen/ls20100209\\_1bv1000109.html](http://www.bundesverfassungsgericht.de/entscheidungen/ls20100209_1bv1000109.html) [hereinafter BVerfGE].

because human beings, as such, are necessarily integrated into social relationships.<sup>64</sup>

According to that same judicial decision, the *minimum* should be adapted to the level of development of the community in question and its current lifestyle, subject to constant updating, which constitutes the only room for manoeuvring provided by law;<sup>65</sup> even so, that does not relieve the public authorities of their duty to account for the other public expenses in a transparent and comprehensible manner, and to calculate such expenses using a reliable and consistent method.<sup>66</sup>

#### 4. Substantive and Procedural Healthcare Law<sup>67</sup>

As we know, rights (*Subjektive Rechte*) may be understood from both the substantive and procedural perspectives, since procedural law is intended to ensure the practical enforcement of such rights.<sup>68</sup> It can no longer be doubted that the necessary means by which a substantive right can be realized (that is to say, a procedural right) forms an integral part of the structure of the right in an autonomous manner.

The same approach is well-known in relation to fundamental rights, where the combination of fundamental rights, organization, and procedure known as *due process* for fundamental rights (related to the procedural aspects of constitutional freedoms) is often considered one means – even the *only* means – of producing results in harmony with fundamental rights.<sup>69</sup> From the standpoint of administrative law,

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64. Pedro Aberastury et al., *Soziale Rechte in Stufen: Überwindung Einer alten Debatte?* [*Social Rights in Stages: Overcoming an Old Debate*] (Sommermann, 2013) [hereinafter Sommermann]. Karl-Peter Sommermann indicates that prior to this Federal Constitutional Court Judgment (BVerfG 9 Feb. 2010), there were countless cases in which the claimants were granted an extension of their claims based on the violation of the principle of equal treatment before the law, alleging that the group to which the claimant belonged obtained benefits inferior to those of another group, without any justification for such unequal treatment. These days, however, the right to the existential minimum is derived directly from the Constitution.

65. See BVerfGE, *supra* note 63.

66. See *id.*

67. See Perlingeiro, *supra* note 53, at 45.

68. Angelo Falzea, *Introduzione alle scienze giuriche: il concetto del diritto* [*Introduction to science giuriche: the concept of law*], 6 (Milão, Giuffrè 6 ed. 2008).

69. See Häberle, Peter. *Grundrechte im Leistungsstaat. Veröffentlichungen der Vereinigung der Deutschen Staatsrechtslehrer (VVDStRL)*. Berlin: De Gruyter, 1972, v. 30, p. 49 et seq.; Alexy, *supra* note 58, at 427-38. Alexy refers to “fundamental rights as procedural guarantees”, associating them with the reproduction and conceptu-

effective judicial protection and administrative procedure are the main guarantees of citizens' rights vis-à-vis the public administrative authorities.

Public policies which, according to Ana Paula Barcellos, generally refer to "coordinating the means at the State's disposal, harmonizing the State activities with those of the individual in order to achieve socially relevant objectives determined by policy"<sup>70</sup> fall into the same context. According to Javier Barnes, they include the third generation of administrative procedures, besides the instruments and laws developed around the new forms of governance.<sup>71</sup>

Regarding the role of procedural law as a condition precedent for enforcing substantive right vis-à-vis the public authorities, Hans Wolff *et al.* affirm that "substantive right must penetrate procedure and that fundamental rights must be implemented through procedure."<sup>72</sup>

With the same guidelines in mind, Article 33 of the Model Code of Administrative Jurisdiction for Euro-America, stipulates that "without prejudice to obtaining provisional measures, it is not possible to petition for a court order to perform a certain action or give or pay a sum without first applying to the appropriate public authority,"<sup>73</sup> which should not be confused with an administrative appeal

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alization of a development present in the case law of the Federal Constitutional Court (op. cit., p. 429).

70. Ana Paula Barcellos, *A construção de um mínimo existencial em matéria de prestações de saúde [The Construction of an Existential Minimum in Health Services]*, DIREITOS SOCIAIS: FUNDAMENTOS, JUDICIALIZAÇÃO E DIREITOS SOCIAIS EM ESPÉCIE [SOCIAL RIGHTS: FUNDAMENTALS, JUDICIAL REVIEW AND SPECIFIC SOCIAL RIGHTS] 112 (Lumen Juris. Ed. 2008).

71. Javier Barnes, *Tres generaciones de procedimiento administrativo [Three Generations of Administrative Procedure]*, TENDENCIAS ACTUALES DEL PROCEDIMIENTO ADMINISTRATIVO EN LATINOAMÉRICA Y EUROPA [CURRENT TRENDS IN ADMINISTRATIVE PROCEDURE IN LATIN AMERICA AND EUROPE] 119, 119-64 (Konrad Adenauer ed. 2012).

72. HANS J. WOLF ET AL., DIREITO ADMINISTRATIVO [ADMINISTRATIVE LAW] 255, 490 (Fundação Calouste Gulbenkian ed., António F. de Souza trans., 2006) [hereinafter WOLF]; see also HARTMUT MAURER, DERECHO ADMINISTRATIVO ALEMÁN [GERMAN ADMINISTRATIVE LAW] 479 (Univ. Nacional Autónoma de Méx., Investigaciones Jurídicas, 2012); Cidade do México, UNAM, 2012. P. 479.

73. RICARDO PERLINGEIRO & KARL-PETER SOMMERMANN, EURO-AMERICAN MODEL CODE OF ADMINISTRATIVE JURISDICTION: ENGLISH, FRENCH, GERMAN, ITALIAN, PORTUGUESE AND SPANISH VERSIONS 130 (Livraria Icarai ed., 2014) [hereinafter EURO-AMERICAN MODEL]. Along the same lines, see Precedent 2 of the Higher Court of Justice [Superior Tribunal de Justiça] (A writ of habeas data is not admissible unless the administrative authority refused the information in question). A compliance with the previous administrative procedure as a prerequisite for judicial protection in terms of social benefits has sparked controversies in Bra-

prior to judicial intervention — an option of the interested party which, even after it has been initiated, does not prevent urgent judicial measures on the claimant's behalf.<sup>74</sup>

The imperative nature of a prior procedural right (or duty), even when associated with legislative public policies, is especially relevant to social rights that are subject to the law-maker's margin of discretion in policy-making, precisely the claims from which the *existential minimum* is extrapolated, in which the right to the services of the State depends on giving all concerned a prior opportunity to have a chance to participate.<sup>75</sup>

In this context, the administrative procedure is used to search for objective, clear, verifiable criteria to prioritize products and services for the elderly within the resources allocated to healthcare, oriented by the primacy of an existential minimum for older people.

In fact, judicial claims for the supply of medicines or healthcare services (substantive rights) are naturally supported by the financial resources allocated to the public health care budget in general (procedural rights).<sup>76</sup>

Since a judicial action of that kind affects a variety of users of that same public service, it means that granting a judicial claim should be conditional on prior restructuring of the administrative authority

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zilian courts; the subject is currently in the process of harmonization by the Federal Supreme Court.

74. Regarding the difference between prior administrative procedures and prior administrative remedies, see ALLAN R. BREWER-CARIAS, *PRINCIPIOS DEL PROCEDIMIENTO ADMINISTRATIVO EN AMÉRICA LATINA* 287, 294 (Legis Editores S.A. ed., 2003), <http://www.allanbrewercarias.com/Content/449725d9-f1cb-474b-8ab2-41efb849fea5/Content/II.1.100.pdf> (last visited Nov. 28, 2016); Augustin Gordillo, *El Procedimiento Administrativo* [Administrative Procedure], 4 *TRATADO DE DERECHO ADMINISTRATIVO [TREATISE ON ADMINISTRATIVE LAW]* 106-07 (Editorial Porrúa ed., 7th ed. 2004). Regarding the optional character of administrative remedies, see Ada Pellegrini Grinover et al., *Código Modelo de Processos Administrativos – Judicial e Extrajudicial – para Ibero-América*, 29 *SEMINÁRIO DEMANDAS REPETITIVAS NA JUSTIÇA FEDERAL: POSSÍVEIS SOLUÇÕES PROCESSUAIS E GERENCIAIS* 107-120 (Conselho da Justiça Federal, 1st ed. 2014), <http://dx.doi.org/10.2139/ssrn.2250852> (last visited Nov. 28, 2016); EURO-AMERICAN MODEL, *supra* note 73, at art. 32. *But see* CONSTITUIÇÃO FEDERAL [C.F.] [CONSTITUTION] art. 217 ¶ 1 (Braz.) (providing that courts should not admit actions concerning the sports competitions and disciplinary matters until all the levels of appeal have been exhausted with the relevant administrative authority); 1 LEONARDO GRECO, *INSTITUIÇÕES DE PROCESSO CIVIL [INSTITUTIONS OF CIVIL PROCEDURE]* 233 (Forense, 2009).

75. See PIEROTH, *supra* note 61, at 28; WOLF, *supra* note 72, at 488-89.

76. See Ricardo Perlingeiro, *Recognizing the Public Right to Healthcare: the Approach of Brazilian Courts*, 32 *REVISTA PORTUGUESA DE SAÚDE PÚBLICA* 134, 141 (2014).

with respect to the distribution of the resources available for the subsequent claims presented to the authority out of court.

For that reason, the enforceability and judicial review of citizens' rights to healthcare must necessarily entail the prior or simultaneous judicial review of the procedural rights; in other words, it is not just the claim to a medicine or healthcare product or service (substantive right) that is asserted in court, but above all the claim to have access to the administrative procedure (procedural right) to obtain the healthcare product or service, which means that judicial protection plays a greater, more powerful role in ensuring equality among all of the users of the public healthcare service.

If the administrative procedure is not reviewed by the court for some reason, the judicial claim (substantive right) must be supported by other financial resources unrelated to public healthcare services because the judicial protection of an individual claim is subordinate to the need for the continuity of essential public services.

It is not permissible for one claimant's statutory right to be exercised by sacrificing another individual's right to an essential public service.<sup>77</sup>

## **5. The Impact of the Limited Budget of the Public Powers on Healthcare Policies: Legislation; Public Budget; Public Healthcare Management**

Even though substantive rights are subordinate to procedural rights, that fact alone does not prevent conflicts involving the enforceability and judicial review of healthcare rights, especially conflicts based on the public powers' lack of funding. It is clearly possible to imagine that an administrative authority, despite complying properly with all the rules of procedure, might have insufficient funds to meet numerous unexpected demands. In fact, the financial realities of the public powers affect healthcare rights on three different levels:

- (a) on the legislative level, to decide which rights will be implemented, considering the *existential minimum*, on the one hand, and the margin of discretion in policymaking, subject to the principle

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<sup>77</sup>. On the enforcement of judicial decisions against health authorities, *see id.* at Chapter 7.

of proportionality, to extend the right to services beyond that *minimum*, on the other;<sup>78</sup>

(b) on the public budget level, to decide how much and in what manner funds will be spent on the *existential minimum* and other healthcare implemented by the law-makers, considering, on the one hand, the essential financial resources to ensure effective exercise of the existing healthcare rights and, on the other, the margin of discretion in policymaking, subject to the principle of proportionality, to extend the funding to peripheral services associated with such healthcare rights;<sup>79</sup>

(c) on the level of the administrative authority, to decide which healthcare services will be offered and how, considering, on the one hand, that the right to the *existential minimum* and other healthcare implemented by the law-makers is dependent on the existing budget resources and, on the other, the margin of administrative discretion, subject to the principle of proportionality, capable of presenting specific justifications for using the financial resources necessary for the exercise of such healthcare rights.<sup>80</sup>

## 6. Conflicts Involving Healthcare Resulting from a Shortage of Public Financial Resources

Consequently, from the financial perspective, healthcare disputes that end up in court may be examined from two different angles.

First of all, in reference to the constitution (existence) of the very right to healthcare, in the case of a gap between an individual's claim and the right to the healthcare actually implemented by the law-maker, in a typical constitutional court case, where the financial resources will be used, on the one hand, to identify the existential minimum and, on the other, to review the law-maker's margin of discretion to extend the scope of the healthcare services beyond the minimum established.

In view of the existential minimum, the right to healthcare arises out of the Constitution, in conjunction with the essence of a fundamental right to healthcare or in accordance with the principle of human dignity.<sup>81</sup> In such cases, the law-maker has no margin of discretion at all, so the enforceability and potential for judicial review of the

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78. Ricardo Perlingeiro, *Procedural and Substantive Judicial Review of the Right to Health in Brazil* 2 BRICS L.J. 15, 23-26 (2015) [hereinafter *Procedural and Substantive Judicial Review*].

79. *Id.*

80. *Id.*

81. On the basic principles of the right to a certain minimum, see ONU, *supra* note 42.

right to healthcare are automatic<sup>82</sup> and not dependent on the law-makers, whose failure to provide for the existential minimum is considered unconstitutional and subject to judicial review.<sup>83</sup>

The second perspective in which we may view conflicts involving healthcare and public funding is not concerned with the creation of healthcare rights; rather, it takes the existence of such rights for granted and focuses on the enforceability and judicial review of such rights.

From this standpoint, the conflict may have two different causes: public budget constraints or the behaviour of the administrative authority in question.<sup>84</sup>

In the first case, if the *existential minimum* and the healthcare rights generally created by law are underfunded by the budget or if they violate, by their very nature, the principle of the Rule of Law,<sup>85</sup> then opportunities arise for judicial hearings of individual demands and the enforcement of judgements.

The public budget is a decisive factor in guaranteeing a legal system that is democratic in the distribution of social benefits, in view of rights which, although arising out of the Constitution, depend on the law in order to be enforceable.<sup>86</sup> The public budget, however, is not

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82. With respect to the existential minimum, the positive right to social welfare creates an obligation on the State that is originally tied to the Constitution and therefore judicially enforceable. Alexy, *supra* note 58, at 466; *see also* GILMAR FERREIRA MENDES ET AL., CURSO DE DIREITO CONSTITUCIONAL [CONSTITUTIONAL LAW COURSE] 253 (Saraiva, 2007). According to Italian Constitutional Court precedents, there is a “minimum core” of the right to services that “cannot be eliminated.” Giampiero Cilione, DIRITTO SANITARIO [RIGHT TO HEALTH] 21 (Santarcangelo di Romagna: Maggioli Editore, 2005).

83. Sommermann admits that in extreme cases it would be possible to invoke the right to an existential minimum, directly from the Constitution, without calling up a constitutional court. Sommermann, *supra* note 64. According to him, in Germany in the 1950s there were gaps in German social legislation and financial resources were scarce. *Id.* At the time, when many refugees were displaced to West Germany, where the cities were still suffering from the destruction caused by the war, the public authorities and “civil” courts (without administrative jurisdiction) applied the general clause of police power to ensure the existential minimum. *Id.* For example, they required families to shelter the homeless. According to Sommermann, in the absence of sufficient social legislation, it is necessary to provide direct protection by means of general rules interpreted in the light of constitutional obligations to guarantee the existential minimum. *Id.*

84. *Procedural and Substantive Judicial Review*, *supra* note 78, at 26-29.

85. “A country’s difficult financial situation does NOT absolve it from having to take action to realize the right to health.” *Fact Sheet*, *supra* note 11.

86. *Procedural and Substantive Judicial Review*, *supra* note 78, at 24.

capable of nullifying the existential minimum or social rights established by law.<sup>87</sup>

In the second case, the conflict arises from the behavior of the relevant administrative authority, which, despite the existence of budgetary resources granted by law, alleges that it does not actually have sufficient funding to meet the healthcare demands.<sup>88</sup> Such situations also involve a conflict with the Rule of Law and allow for judicial protection of the individual vis-à-vis the public authorities.

## 7. Enforcement of Judgements and their Limitations Given the Bankruptcy of the Public Healthcare Authorities

Theoretically, the shortage of budgetary funding is no obstacle to the enforceability and potential for judicial review of healthcare rights.<sup>89</sup> However, since the administrative authorities are bound to follow the letter of the law and have no means of interpreting the Constitution themselves and applying it directly, the shortage of funding may serve as a justification for not providing social benefits, which will inevitably lead to judicial review; in principle, however, the expropriation of goods and public funding is conditional on the absence of a violation of the public interest or essential service, which means that judicial protection will not always be effective.<sup>90</sup> For exam-

87. Alexy affirms that “The force of the principle that the budget is under the authority of the legislators is not unlimited. It is not an absolute principle. Individual rights can outweigh political-financial reasons.” Alexy, *supra* note 58, at 466. For Alexy, “even the *minimum* fundamental social rights have enormous financial consequences, especially when many people seek to enforce them. Yet that, considered in isolation, does not justify the conclusion that they should not exist.” *Id.* The German Federal Constitutional Court decided that economic aspects cannot be considered in order to refuse to reimburse the insured for new medical treatments necessary to cure life-threatening diseases. BVerfG, 1 BvR 347/98 (Dec. 6, 2005), [http://www.bverfg.de/entscheidungen/rs20051206\\_1bvr034798.html](http://www.bverfg.de/entscheidungen/rs20051206_1bvr034798.html) (last visited Nov. 28, 2016).

88. See generally *Procedural and Substantive Judicial Review*, *supra* note 78.

89. On the enforcement of judicial decisions against administrative authorities, see generally Congrès de L’association Internationale des Hautes Juridictions Administratives, *L’Exécution des Décisions des Juridictions Administratives* [Enforcement of the decisions of administrative jurisdictions] (2004), [http://www.aihja.org/images/users/1/files/2004\\_Congres\\_de\\_Madrid\\_Rapport\\_VIII\\_congres\\_VIII\\_vf.pdf?PHPSESSID=f83dg63dqj61vokoep4kk44fu1](http://www.aihja.org/images/users/1/files/2004_Congres_de_Madrid_Rapport_VIII_congres_VIII_vf.pdf?PHPSESSID=f83dg63dqj61vokoep4kk44fu1) (last visited Nov. 28, 2016).

90. In Brazil, the enforcement of judicial decisions against administrative authorities is generally permitted, unless contrary to public interest. (C.C. 12.016, de 2009, art. 15 (Braz.); C.C. 8.437, de 1992, art 1°, 4° (Braz.); C.C. 9.494, de 1997, art. 1° (Braz.)). Especially in cases of court orders to pay a certain amount of money, enforcement against the administrative authorities is not permitted. C.C. 5868, de

ple, an individual claim for hospitalization for the treatment of a curable illness filed with a public healthcare authority that lacks funding to remedy the lack of beds or doctors – unfortunately, this a very common example in our Brazilian courts.

The claimant's right to hospitalization is unquestionable, but there would be no point in enforcing a judgement that requires sacrificing the rights of another individual with similar needs in order to grant the claimant's demand. The enforcement of such a judgement would depend on resorting to third parties, as by hiring privately owned beds, provided that sufficient public funding is available that has not been earmarked for other essential services. In the enforcement of judgements against administrative authorities, public funding may be expropriated only in the following cases:

- (a) Public property that is not assigned a specific purpose, such as unused land, or public assets in general that have not been assigned a specific purpose, such as funds available from the collection of tax revenue;
- (b) Assets and financial resources allocated to a non-essential, accessory public service of a type that is typically private, such as the costs of government media campaigns or the purchase of luxury cars for official purposes;
- (c) Assets and financial resources earmarked for repayment of past debts, provided that, *in and of themselves*, they are not capable of interrupting the continuity of an essential public service.

Before concerning ourselves with the enforceability and potential for judicial review of healthcare rights, the availability of budget-

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1973, art. 730 *et seq.* (Braz.). An exception in the case of minor amounts payable. C.C. 10.259, de 2001, art. 17, §2°; C.C. 12.153, de 2009, art. 13, §°. Recent precedents, however, have authorised the enforcement of liabilities of any amount in cases of exceptional urgency S.T.F., STA 36-8, 27. Sept. 2005, Reporting Judge Nelson Jobim. Seizure of public funds in favour of a patient in a serious condition is a topic of general public interest, Supremo Tribunal Federal Notícias, *Sequestro de verbas públicas em favour de doente grave é tema de repercussão geral* (Nov. 19, 2012) Notícias STF (Nov. 19, 2012), <http://www.stf.jus.br/portal/cms/verNoticiaDetalhe.asp?idConteudo=224106> (last visited Sept. 19, 2016).

91. Ricardo Perlingeiro, EXECUÇÃO CONTRA A FAZENDA PÚBLICA [ENFORCEMENT AGAINST THE PUBLIC AUTHORITIES] 217-26 (Malheiros eds., 1999).

92. See generally *Juiz Suspende Publicidade Oficial e dá Dinheiro à Saúde* [Judge Suspend Official Advertising and Transfers the Corresponding Funds to Health Care], CONVERSA AFIADA (July 31, 2013), <http://www.conversaafiada.com.br/pig/2013/07/31/juiz-suspende-publicidade-oficial-e-da-dinheiro-a-saude/> (“MPF/RR pede sequestro e bloqueio das contas do Estado de Roraima caso ordem judicial seja descumprida”) [The Federal Prosecutor's Office of Roraima requests that the accounts of the State of Roraima be seized and frozen in case the court order is not enforced].

93. *Procedural and Substantive Judicial Review*, *supra* note 78, at 26.

ary resources, and effective public healthcare management, it is imperative to try to understand the effects of the public authorities' budget constraints, which orient the scope of such rights towards an existential minimum; this tends to be accepted by the whole legal system and reduces conflicts.

In this context, one question is especially relevant: What is the import of the expression *existential minimum* in relation to healthcare for the elderly?<sup>94</sup>

## 8. The Existential Minimum in Procedural Aspects of Healthcare Rights

As mentioned above, it is impossible to define an existential minimum merely objectively without considering the subjective aspects of the individual and of the community in which they live.<sup>95</sup> I shall therefore limit myself to objective factors of the right to an existential minimum.

I shall discuss the right to existential minimum in terms of healthcare, particularly healthcare for the elderly, first in light of the procedural rights pertaining to essential healthcare policies, and second in light of the substantive rights (i.e., essential medicines and healthcare products and services). Regarding public policies,

The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.<sup>96</sup>

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94. Regarding the right to a certain existential minimum in health care, see Ana Paula Barcellos, *A Construção de um Mínimo Existencial em Matéria de Prestações de Saúde* [Building an Existential Minimum for Health Care Services], *DIREITOS SOCIAIS: FUNDAMENTOS, JUDICIALIZAÇÃO E DIREITOS SOCIAIS EM ESPÉCIE*, RIO DE JANEIRO: LUMEN JURIS (2008).

95. Jordi Bonet Pérez, *Dret internacional dels drets humans en períodes de crisi: criteris d'aplicació de les obligacions jurídiques internacionals en matèria de drets econòmics, socials i culturals* [International human rights law in times of crisis: criteria for the application of international legal obligations relating to economic, social and cultural], 46 *REVISTA CATALANA DE DRET PÚBLIC*, 14, 14-46 (2013).

96. See *General Comment 14*, *supra* note 13.

As pointed out by the Committee of Cultural, Social and Economic Rights:<sup>97</sup>

The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect, protect, and fulfill. In turn, the obligation to fulfill contains obligations to facilitate, provide, and promote. The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfill requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures towards the full realization of the right to health.<sup>98</sup>

As we know:

The right to health does not mean the right to enjoy good health or that the governments of poor countries have to establish expensive healthcare services that they cannot afford. It means that governments and public authorities need to establish policies and plans of action intended to ensure that everyone has access to healthcare as quickly as possible. Attaining that goal is a challenge that must be faced by both the society in charge of protecting human rights and healthcare professionals.<sup>99</sup>

Yet how can poor countries with resource limitations be held to the same human rights standards as rich countries?<sup>100</sup>

Steps towards the full realization of rights must be deliberate, concrete, and targeted as clearly as possible towards meeting a government's human rights obligations. All appropriate means, including the adoption of legislative measures and the provision of judicial remedies as well as administrative, financial, educational, and social measures, must be used in this regard. This neither requires nor precludes any particular form of government or economic system being used as the vehicle for the steps in question.

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97. In May 2013, the Committee was authorized to receive and evaluate communications of the type mentioned in the Optional Protocol to the International Pact on Economic, Social and Cultural Rights, which was adopted by the United Nations General Assembly on December 10, 2008 via resolution A/RES/63/117; open for signature on September 24, 2009, in New York; entered into force on May 5, 2013. G.A. Res. 63/117 (Dec. 10, 2008), [http://direitoshumanos.gddc.pt/3\\_1/IIIPAG3\\_1\\_5.htm](http://direitoshumanos.gddc.pt/3_1/IIIPAG3_1_5.htm) (last visited Nov. 28, 2016).

98. *General Comment 14*, *supra* note 13.

99. Mary Robinson, *El derecho a la salud [The Right to Health]*, 19 BOLETÍN DERECHOS HUMANOS 1 (2010), [http://www.ohchr.org.gt/documentos/boletines/boletin\\_19.pdf](http://www.ohchr.org.gt/documentos/boletines/boletin_19.pdf) (last visited Nov. 28, 2016).

100. WHO, *Series of publications on health and human rights, Twenty-five questions and answers about health and human rights* 14 (2002), [http://whqlibdoc.who.int/publications/2002/9243545698\\_spa.pdf](http://whqlibdoc.who.int/publications/2002/9243545698_spa.pdf) (last visited Nov. 28, 2016) [hereinafter *Series of Publications*].

The principle of *progressive realization* of human rights imposes an obligation to move as expeditiously and effectively as possible towards that goal.<sup>101</sup> It is therefore relevant to both poorer and wealthier countries, as it acknowledges the constraints due to the limits of available resources, but requires all countries to show constant progress in moving towards full realization of rights.<sup>102</sup> Any deliberately retrogressive measures require the most careful consideration and need to be fully justified by reference to the totality of the rights provided for in the human rights treaty concerned and in the context of the full use of the maximum available resources. In this context, it is important to distinguish the *inability* from the *unwillingness* of a State party to comply with its obligations. During the reporting process, the State party and the committee identify indicators and national benchmarks to provide realistic targets to be achieved during the next reporting period.<sup>103</sup>

It is necessary to define an existential minimum in keeping with the principle of proportionality, as pointed out by the Committee on Economic, Social and Cultural Rights:

The most appropriate feasible measures to implement the right to health will vary significantly from one State to another. Every State has a margin of discretion in assessing which measures are most suitable to meet its specific circumstances. The International Covenant on Economic, Social and Cultural Rights, however, clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health. This requires the adoption of a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks. The national health strategy should also identify the resources available to attain defined objectives,<sup>104</sup> as well as the most cost-effective way of using those resources.

Thus, according to the Committee: "The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:"<sup>105</sup>

(a) Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be avail-

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101. *Id.*

102. Helena Nygren-Krug, *Health and Hum. Rts., In 25 Questions and Answers, CONCEPTS AND PRACTICE OF HUMANITARIAN MED.* 25 (S. William A. Gunn and Michele Masellis eds., 2008).

103. *Series of Publications, supra* note 100.

104. *See General Comment 14, supra* note 13.

105. *Id.*

able in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs,<sup>106</sup> as defined by the WHO Action Programme on Essential Drugs.

(b) Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:<sup>107</sup>

(i) Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact,<sup>108</sup> without discrimination on any of the prohibited grounds.

(ii) Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities, and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.<sup>109</sup>

(iii) Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.<sup>110</sup>

(iv) Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.<sup>111</sup>

(c) Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. re-

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106. *Id.* at 132.

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.* at 132-33.

111. *Id.* at 133.

spectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.<sup>112</sup>

(d) Quality. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital<sup>113</sup> equipment, safe and potable water, and adequate sanitation.

In General Comment No. 3, the Committee on Economic, Social and Cultural Rights confirms that State parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care.<sup>114</sup> Read in conjunction with more contemporary instruments, such as the Program of Action of the International Conference on Population and Development, 28 the Alma-Ata Declaration provides compelling guidance on the core obligations arising from Article 12.<sup>115</sup> Accordingly, in the Committee's view, these core obligations include at least the following obligations:<sup>116</sup>

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; [ . . . ]<sup>117</sup>

(e) To ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which

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112. *Id.*

113. *Id.*

114. *Id.* at 143.

115. *Id.* at 143-44.

116. *Id.* at 144; see Anand Grover, *Thematic study on the realization of the right to health of older persons by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, U.N. Doc. A/HRC/18/37 (July 4, 2011), [http://www2.ohchr.org/english/bodies/hr\\_council/docs/18session/A-HRC-18-37\\_en.pdf](http://www2.ohchr.org/english/bodies/hr_council/docs/18session/A-HRC-18-37_en.pdf) (last visited Nov. 28, 2016).

117. *General Comment 14*, *supra* note 13, at 144. (“(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone; (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs.”).

the strategy and plan of action are devised, as well as their content, shall give<sup>118</sup> particular attention to all vulnerable or marginalized groups.

## 9. The Existential Minimum in Substantive Aspects of Healthcare Rights

Regarding substantive rights, such as rights to essential healthcare products and services and medicines,

[t]he fact that the right to health should be a tangible programmatic goal does not mean that no immediate obligations on States arise from it. In fact, States must make every possible effort, within available resources, to realize the right to health and to take steps in that direction without delay. Notwithstanding resource constraints, some obligations have an immediate effect, such as the undertaking to guarantee the right to health in a non-discriminatory manner, to develop specific legislation and plans of action, or other similar steps towards the full realization of this right, as is the case with any other human right. States also have to ensure a minimum level of access to the essential material components of the right to health, such as the provision<sup>119</sup> of essential drugs and maternal and child health services.

The 1978 Alma Ata Conference on primary health care recognized that essential drugs are vital for preventing and treating illnesses which affect millions of people throughout the world.<sup>120</sup> Essential drugs save lives and improve health.<sup>121</sup>

In 1981, the WHO established the Action Program on Essential Drugs to support countries implementing national drug policies and to work towards rational use of drugs.<sup>122</sup> This work was broadened in 1998 when WHO created the department of Essential Drugs and Other Medicines (“EDM”), combining the responsibilities of the former DAP with WHO’s global efforts to promote quality, safety, efficacy, and accurate information for all medicines.<sup>123</sup>

In fact, the difficulty of putting this into practice is reflected in the long and more categorical 2002 definition:

Essential medicines are those that satisfy the priority health care needs of the population. They are selected with due regard to

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118. *Id.*

119. *Fact Sheet, supra* note 11, at 5.

120. Sophie Pilon, *Essential Drugs: Practical guide intended for physicians, pharmacists, nurses and medical auxiliaries*, MEDECINS SANS FRONTIERES (2016), [http://refbooks.msf.org/msf\\_docs/en/essential\\_drugs/ed\\_en.pdf](http://refbooks.msf.org/msf_docs/en/essential_drugs/ed_en.pdf).

121. *Id.*

122. *Id.*

123. *Id.*

public health relevance, evidence<sup>124</sup> on efficacy and safety, and comparative cost-effectiveness.

Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford. The implementation of the concept of essential medicines is intended to be flexible and adaptable to many different situations; exactly which medicines are regarded as essential remains a national responsibility.<sup>125</sup>

General Comment of the Committee of Cultural, Social and Economic Rights of May 14, 2000, is particularly relevant to access to essential medicines. Here the Committee states that the right to medical services in Article 12.2 (d) of the ICESCR includes the provision of essential drugs “as defined by the WHO Action Programme on Essential Drugs.”<sup>126</sup> According to the latest WHO definition, essential medicines are: “those that satisfy the priority health care needs of the population. Essential medicines are selected with due regard to disease prevalence, evidence on efficacy and safety, and comparative cost-effectiveness.”<sup>127</sup>

Essential medicines are intended to be available within the context of functioning health systems at all times, in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford. The implementation of the concept of essential medicines is intended to be flexible and adaptable to many different situations; exactly which medicines are regarded as essential remains a national responsibility.

## 10. The Existential Minimum in Healthcare for the Elderly

First of all, regarding public policies that establish minimum levels of healthcare for the elderly, the Pan American Health Organization (“PAHO”)<sup>128</sup> affirms that it is necessary to have a plan of action

124. *Essential Medicines*, WHO, [http://www.who.int/topics/essential\\_medicines/en/](http://www.who.int/topics/essential_medicines/en/) (last visited Nov. 28, 2016).

125. WHO, *WHO Policy Perspectives on Medicines*, <http://apps.who.int/medicinedocs/en/d/Js2296e/1.html> (last visited Nov. 28, 2016).

126. *General Comment 14*, *supra* note 13.

127. *Id.*

128. *Plan de acción sobre la salud de las personas mayores incluido el envejecimiento activo y saludable* [Plan of action for the health of the elderly, including active and healthy ageing], ORGANIZACIÓN PANAMERICANA DE LA SALUD, [http://www.mayor\\_essaludables.org/plan-de-accion](http://www.mayor_essaludables.org/plan-de-accion) (last visited Sept. 19, 2016).

for the health of older persons, including active and healthy aging, taking the following factors into account: a) the health of older persons in public policies; b) the suitability of the health systems to meet the challenges associated with the aging of the population; c) training of the human resources need to meet that challenge; and d) creation of the capacities to generate the information needed to carry out and evaluate actions to improve the health of the elderly population.<sup>129</sup>

To quote from the Vienna International Plan of Action on Aging adopted by the World Assembly on Aging held in Vienna, Austria from July 26 to August 6, 1982:<sup>130</sup>

[. . .] Recommendation 10. Health and health-allied services should be developed to the fullest extent possible in the community. These services should include a broad range of ambulatory services such as: day-care centres, out-patient clinics, day hospitals, medical and nursing care and domestic services. Emergency services should be always available. Institutional care should always be appropriate to the needs of the elderly. Inappropriate use of beds in health care facilities should be avoided. In particular, those not mentally ill should not be placed in mental hospitals. Health screening and counselling should be offered through geriatric clinics, neighbourhood health centres or community sites where older persons congregate. The necessary health infrastructure and specialized staff to provide thorough and complete geriatric care should be made available. In the case of institutional care, alienation through isolation of the aged from society should be avoided inter alia by further encouraging the involvement of family members and volunteers.

[. . .] Recommendation 13. Efforts should be intensified to develop home care to provide high quality health and social services in the quantity necessary so that older persons are enabled to remain in their own communities and to live as independently as possible for as long as possible. Home care should not be viewed as an alternative to institutional care; rather, the two are complementary to each other and should so link into the delivery system that older persons can receive the best care appropriate to their needs at the least cost. Special support must be given to home care services, by providing them with sufficient medical, paramedical, nursing and technical facilities of the required standard to limit the need for hospitalization.<sup>131</sup>

Peláez & Ferrer propose, among other suggestions, “a public and private budget to invest in low-cost technology and essential medicines for the control of common illnesses among the elderly and pro-

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129. See generally *id.*

130. *Vienna International Plan of Action on Aging*, ONU (1982), <http://www.un.org/es/globalissues/ageing/docs/vipaa.pdf>.

131. *Id.*

hibition of discrimination against the elderly in public and private healthcare institutions.”<sup>132</sup>

Regarding medicines and healthcare products and services essential to the health of the elderly, we shall once again quote the Committee on Economic, Social and Cultural Rights:

With regard to the realization of the right to health of older persons, the Committee, in accordance with paragraphs 34 and 35 of General Comment No. 6 (1995), reaffirms the importance of an integrated approach, combining elements of preventive, curative and rehabilitative health treatment. Such measures should be based on periodical check-ups for both sexes; physical as well as psychological rehabilitative measures aimed at maintaining the functionality and autonomy of older persons; and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.<sup>133</sup>

In fact, the substantive rights to healthcare for the elderly concern the medicines and healthcare products and services that are essential to combat illness that generally occur more frequently after reaching a certain age: primary healthcare and chronic illnesses, palliative care, and geriatric illnesses, such as Alzheimer’s disease.

In Brazil, the basic healthcare benefits for the elderly were approved in 2006 by the Ministry of Health.<sup>134</sup> It is also worth mentioning the Supplementary Health Plan for the Elderly, adopted in Brazil in 2012.<sup>135</sup> From the standpoint of substantive rights, the benefits (medicines, products and services) are provided by the SUS<sup>136</sup> [Brazil’s uni-

132. Paláez, *supra* note 6.

133. *General Comment 14*, *supra* note 13.

134. Portaria n°2.528, de 19 Oct. 2006, Ministro de Estado de Saude, (Braz.) <http://dtr2001.saude.gov.br/sas/PORTARIAS/Port2006/GM/GM-2528.htm>.

135. *Plano de Cuidado para Idosos na Saúde Suplementar*, AGÊNCIA NACIONAL DE SAÚDE, [http://bvsms.saude.gov.br/bvs/publicacoes/plano\\_cuidado\\_idosos.pdf](http://bvsms.saude.gov.br/bvs/publicacoes/plano_cuidado_idosos.pdf) (last visited Sept. 19, 2016).

136. In the USA, Medicare (publicly funded program) offers coverage for nearly 40 million elderly or handicapped Americans. Medicare Part A covers the majority of Americans over the age of 65 and provides hospitalization insurance coverage. Although Medicare Part B is optional, almost all eligible parties sign up for it because of the substantial federal grants for the program. Medicare Part B provides supplementary medical coverage for medical check-ups and diagnostic exams, among other things. Many beneficiaries of Medicare also get Medigap (the supplementary Medicare insurance) or are covered by their former employer. The Medigap policies are regulated on the federal level and must include specified basic benefits. In the United Kingdom, there are various services provided to the elderly by the NHS, such as: emergency care, generally given in hospitals, and dentists, among others. All such services may or may not involve costs for the patients. In Portugal, health care services are provided by the National Health Service [Serviço Nacional de Saúde (SNS)], where the applicant must satisfy, cumulatively, all the legal requirements in order to be granted the right to the “solidarity

fied health system], based on the primary criterion that the beneficiary must be older than sixty years of age. The medicines, products, and services essential to the entire population are naturally also considered to be essential to the elderly. It is worth mentioning, however, that the SUS also provides for treatment of Alzheimer's<sup>137</sup> and osteoporosis,<sup>138</sup> providing opportunities for adult diapers in certain cases.<sup>139</sup>

## Closing Considerations

Healthcare for the elderly is a fundamental social right, and its essential core, tied to the principles of human dignity and the right to life, is also known as the "existential minimum."

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supplement for the elderly." *Compare Serviço Nacional De Saúde, SERVIÇO NACIONAL DE SAÚDE*, <https://www.sns.gov.pt/sns/servico-nacional-de-saude/> (last visited Nov. 28, 2016); *Executive Summary*, U.S. DEP'T OF JUSTICE, [http://www.justice.gov/atr/public/health\\_care/204694/exec\\_sum.htm](http://www.justice.gov/atr/public/health_care/204694/exec_sum.htm); *HHS Agencies & Offices*, U.S. DEP'T OF HEALTH AND HUM. SERV., <http://www.hhs.gov/about/whatwedo.html> (last visited Nov. 28, 2016), *with NHS: How the Care System Works*, NHS, <http://www.nhs.uk/NHSEngland/AboutNHSservices/social-care-services/Pages/social-care-adults.aspx> (last visited on Nov. 28, 2016).

137. Medicines and treatment against Alzheimer's are supplied through the CEAF (Specialized Component of the Pharmaceutical Aid). The following medicines are subsidized: Donepezila 5mg and 10mg; Galantamina 8mg, 16mg and 24mg; Rivastigmina 2mg/mL and Rivastigmina 1.5mg, 3mg, 4.5mg and 6 mg. Thus, the CEAF provides medicines in an important pharmacological category for the treatment of Alzheimer to all patients who meet the criteria established by the PCDT [Clinical Protocol and Therapeutic Guidelines] for Alzheimer's. See Portaria MS/GM 2.982, (Nov. 26, 2009), MINISTRO DE ESTADO DA SAÚDE, (Braz.); see also Portaria SAS/MS n°843, (Oct. 31, 2002), MINISTRO DE ESTADO DA SAÚDE, (Braz.).

138. The treatment for Osteoporosis is offered through the CEAF; the SUS guarantees effective treatment for patients who fall within the scope of the PCDT for that disease providing access to the following medicines: Pamidronato 30mg injectable, Pamidronato 60mg injectable, Risedronato 5mg/cp, Risedronato 35mg/cp, Raloxifeno 60mg/cp, Calcitonina 50 UI injectable, Calcitonina 100 UI injectable, Calcitonina 200 UI nasal spray, Calcitriol 0.25mcg/cp, Alendronato 10mg/cp (Basic Component of Pharmaceutical Assistance), Alendronato 70mg/cp (Basic Component of Pharmaceutical Assistance). Remember that the enforcement of the Component, which involves the phases of application, evaluation, authorization and renewal of continued treatment, is decentralized from the State Ministries of Health. Portaria SAS/MS n°470, de 23 July 2002, MINISTRO DE ESTADO DA SAÚDE, (Braz.).

139. Cases of geriatric fraud have given rise to increasing numbers of court claims, even though the "Farmácia Popular" [Popular Pharmacy] offers the elderly medical reports, certificates or prescriptions which are ninety percent subsidized by the Ministry of Health, with only the remaining ten percent payable by the patient. *Portal da Saúde*, SNS, <https://portalsaude.saude.gov.br/index.php/cidadao/principal/English/Mais-sobre-english/344-read-more-actions-and-programs> (last visited Sept. 19, 2016).

The right to the existential minimum is automatically enforceable against the public authorities (legislative and administrative), from the standpoint of both procedural and substantive rights.

The budgetary and financial difficulties of the public powers do not nullify the healthcare rights of the elderly or preclude their enforceability and eligibility for judicial review, which are automatic, especially in the case of the right to an existential minimum. However, in a specific case, such budgetary and financial problems may interfere with or limit the exercise of healthcare rights and may also prevent such rights from being created by changing the parameters of what is considered to be the existential minimum.

Defining the existential minimum for healthcare for the elderly requires an analysis that combines objective factors (such as healthcare products/services and medicines considered essential by the scientific community) and subjective factors (the particular circumstances of the individual claimant and the level of development of the community, the current living conditions and the available budget of the relevant public administrative authority), in accordance with the principle of proportionality.

Objective healthcare indicators, considered essentially within the scope of application of the international human rights norms, are given top priority. Subject to respecting the initial objective criterion of an "existential minimum," the national law-makers are granted a margin of discretion based on subjective parameters (individual needs and socioeconomic aspects) in order to increase the scope of the social rights or else to restrict such rights, based on the same subjectivity, in justifiable cases.

The objective aspects to be considered in relation to the existential minimum in health care, especially for the elderly, are the aspects closely correlated with the age of the individual.

From the standpoint of procedural rights, the following points are considered essential: including healthcare for the elderly in public policies; training specialised human resources; prohibiting any age-based discrimination; the existence of elderly day-care centres, outpatient clinics, day hospitals, care in geriatric clinics where the elderly meet, as well as home care, reducing the need for hospitalization.

Within the sphere of substantive rights, the following are considered essential for care for the elderly: periodic check-ups, physical and psychological rehabilitation to ensure that the elderly remain fit

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and independent, and care and attention for patients in the terminal phase of a chronic disease.

